

PRIMARY CARE FACILITY DESIGNATION WORKSHEET

Facility Name: _____ Clinics at Facility: _____

Clinic Address: _____

County: _____ HPSA Facility Serves (Name/ID): _____

Facility is public or non-profit ☐ Yes ☐ No*

☐ Metropolitan

☐ Non-metropolitan

☐ Frontier

1) Provision of Services (one):

☐ More than 50% of facility's primary care services are being provided to residents of a HPSA.

☐ Within 30 minutes of HPSA and facility is accessible to residents of HPSA (i.e., no socioeconomic differences).

To: _____		
Distance by: <input type="checkbox"/> Auto <input type="checkbox"/> Bus <input type="checkbox"/> Other		
Source:		
<input type="checkbox"/> Rand McNally Atlas		
<input type="checkbox"/> Maps-on-us		
<input type="checkbox"/> Other:		
Road Type:	Miles	Minutes
Interstate 1.2		
Primary 1.5		
Secondary 2.0		
Total		

2) Insufficient Capacity (two):

☐ (i) > 8000 outpatient visits per year per FTE of the primary care physicians.

_____ Number of outpatients _____ FTE _____ Outpatients/FTE

☐ (ii) Excessive usage (>35%) of emergency room facilities for routine primary care.

☐ (iii) Waiting time for appointments > 7 days for established patients, or _____ days

☐ > 14 days for new patients for routine health services. _____ days

☐ (iv) Facility waiting time > 1 hour when patients have appointments, or _____ hours

☐ > 2 hours for patients treated on a walk-in basis. _____ hours

*Reject application if not public or non-profit

Applicant Reminders:

- Applicant Requests:**

- Rational:**

- Signature:** _____ **Date:** _____

Notes:
